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HILL-BURTON ENFORCEMENT: A PROPOSED REMEDY TO CURE HOSPITAL INERTIA

INTRODUCTION

The concern for adequate health care for all is not a new phenomenon. In 1946, in response to the need for more health care facilities, Congress passed the Hospital Survey and Construction Act,¹ commonly known as the Hill-Burton Act.² The Act authorized grants with which states survey their hospitals and public health centers and plan construction of additional facilities.³ The Act's primary purpose was to facilitate construction,⁴ but Congress added a provision requiring hospitals to provide a reasonable volume of hospital services to indigents.⁵ The provision lay dormant for 20 years and was rarely enforced.⁶ In the 1970s, however, a rash of litigation to enforce the free health care provision led the Department of Health, Education and Welfare to issue regulations governing the provision.⁷ These regulations came as a reaction to judicial interpretation of the Act and defined its compliance provisions. Critics view the regulations as being beyond the scope of the Act and as having converted Hill-Burton into an alternative source of Medicaid.⁸ Critics also argue the regulations are unconstitutional.⁹

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1. Title VI of the Act of August 13, 1946, ch. 958 § 2, 60 Stat. 1041. The statute, as amended, is codified at 42 U.S.C. §§ 291-291(o) (1982).
 2. The Hill-Burton Act is named after its two principal sponsors, Sen. Lister Hill (D-Ala.) and Sen. Harold H. Burton (R-Ohio).
 3. The purpose of the Act is
[t]o assist the states in making a careful State-wide survey of the hospitals and health facilities in the State in order to determine where additional facilities are needed and to prepare a State-wide program for new construction so that all people of the state may have adequate health and hospital service.
Hospital Construction Act: Hearings on S. 191 Before the Senate Comm. on Education and Labor, 79th Cong., 1st Sess. 8 (1945) (statement of Sen. Hill) [hereinafter cited as *1945 Hearings*].
 4. *See id.*
 5. 42 U.S.C. § 291(c)(e) (1982) provides that
[t]he State plan shall provide for adequate hospitals, and other facilities for which aid under this part is available, for all persons residing in the State, and adequate hospitals (and such other facilities) to furnish needed services for persons unable to pay therefore. Such regulations may also require that . . . (2) there will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefore, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.
 6. *See infra* note 39 and accompanying text.
 7. 42 C.F.R. §§ 53.111-.113, 124.501-513 (1986).
 8. *See, e.g.,* Note, *Due Process for Hill-Burton Assisted Facilities*, 32 VAND. L. REV. 1469, 1474 (1979) (author argues that the expansive nature of the regulations promulgated by Health and Human Services to clarify the Hill-Burton assurances has transformed the Act into an alternative source of Medicaid).
 9. *See generally id.*; Blumstein, *Court Action, Agency Reaction: The Hill-Burton Act as a Case Study*, 69 IOWA L. REV. 1227 (1984). Professor Blumstein argues that the principles of

This note suggests that the regulations were necessary to enforce the conditions to which the hospitals agreed in exchange for federal funding. The note discusses the need for health care for the indigent, examines the Hill-Burton Act, and shows that uncompensated health care to the indigent was an important concern of Congress in enacting Hill-Burton. It then looks at the effect of Hill-Burton as originally passed, the hospitals' failure to provide free health care and the judicial activism that led to the 1972 and 1979 regulations. Finally, it analyzes the constitutional objections to the amendments, looks at the proposed rules recently suggested by the Department of Health and Human Services, and proposes further regulation to compel hospital compliance.

THE NEED FOR FREE HEALTH CARE

Today, hospital bills can amount to thousands of dollars.¹⁰ Annual per-capita spending on medical care in the United States exceeds \$1,000.¹¹ Of the \$371 billion spent in the U.S. in 1985,¹² public sources provided forty cents of every dollar,¹³ and all third parties combined financed 92 percent of hospital care services.¹⁴

The exorbitant cost of health care most adversely affects the indigent. Those who do not work cannot participate in group employment policies, which feature relatively low premium rates.¹⁵ Insurance has increased access to care and provides treatment of patients who

fairness for federal grantees announced in *Pennhurst v. Halderman*, 451 U.S. 1 (1981) (see *infra* notes 87-95 and accompanying text) would seem to apply to constrain agency rulemaking discretion, especially when, as in the Hill-Burton context, agency discretion was exercised only in response to criticism by federal district judges. Blumstein also argues that the changes in the provisions of the Hill-Burton regulations go far beyond anything reasonably foreseeable by the grantee hospitals. *Id.* at 1259.

10. The average cost per patient day in 1983 was \$369, while the average cost per patient stay was \$2,789. See BUREAU OF THE CENSUS, U.S. DEPARTMENT OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES: 1986, at 109 (106th ed. 1985).
11. Health expenditures amounted to \$1,721 per person in 1985, with 59 percent coming from the private sector, mostly through private health insurance and from consumers and their families. The remaining 41 percent was funded through government programs, principally Medicare and Medicaid. See Levit, Lazenby & Waldo, *National Health Expenditures, 1985*, 8 HEALTH CARE FINANCING REV. 1 (1986) [hereinafter cited as *National Health Expenditures*].
12. The amount spent on health care in 1985 equalled 10.7 percent of the Gross National Product. *Id.* at 8.
13. Federal payments amounted to \$124.4 billion, and \$50.4 billion came from state and local governments. Public programs financed 39.7 percent of all personal health care expenditures, including 53.8 percent of all hospital care, 29.1 percent of all physician services, and 46.9 percent of all nursing home care. See *id.* at 13-17.
14. All third parties combined—private health insurers, government, private charities and industries—financed 71.6 percent of the \$371.4 billion spent for personal health care in 1985, covering 90.7 percent of hospital care services, 73.7 percent of physicians' services, and 42.1 percent of the remainder, which consists of those personal health care expenditures other than those for hospital care, physicians' services and nursing home care. See *id.* at 16-18.
15. See K. DAVIS & C. SCHOEN, *HEALTH AND THE WAR ON POVERTY: A TEN-YEAR APPRAISAL* 9 (1978) (group insurance policies provided by employers have lowered premiums and increased access to insurance for those in lower income brackets, but many indigents have no jobs, and thus do not have this access to low-cost insurance).

had been shut out of the medical market.¹⁶ Private insurance companies, however, are reluctant to write comprehensive health insurance policies for the poor, who, because of their multiple health problems, are considered a bad risk.¹⁷ Even for those who can afford it, the typical medical insurance policy provides only limited coverage.¹⁸

Since Medicare and Medicaid came into being in 1966,¹⁹ access to medical care for the people eligible to receive it has markedly improved.²⁰ Eligibility standards for Medicaid, however, exclude a great number of people.²¹ Because of Medicaid's multiple criteria for eligibility, about 12 million people with income below the federal poverty

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16. Unlike other goods or services for which the consumer pays the provider directly, health care payments are often handled by a financial agent, a third party. Insurance has increased access to care, resulting in the increase of care for those who usually could not afford it. See Gibson, Levit, Lazenby & Waldo, *National Health Expenditures, 1983*, 6 HEALTH CARE FINANCING REV. 11 (1984).
 17. The poor bear many social costs imposed upon them by a negligent society. These result in poor health, which the indigent are largely unable to avoid. The poor suffer from the high risks of injury, sickness, or poor health they incur in risky and physically demanding jobs or through industrial pollution and waste in the communities in which they live. Additionally, poor health prevents the disadvantaged from competing equally in the marketplace. Oftentimes the disadvantaged are handicapped from birth, off to a slow start because of inadequate care and nutrition during pregnancy. Poor health care during childhood and adulthood is recognized as causing a rapid loss of functional ability, and this loss becomes even more apparent as people move into middle and old age. Because of the poor health from which the indigent suffer, insurance policies for the poor are usually limited in benefits and require the payment of a premium far in excess of the expected benefits. Often riders attached to policies give companies the option of dropping coverage should the beneficiary become a poor risk. For the disabled poor or those with obviously identifiable poor health, companies are unwilling to provide any coverage at all. K. DAVIS & C. SCHOEN, *supra* note 15, at 8-10.
 18. For an informative discussion of the nature and extent of private health insurance coverage, See A. SCHNEIDER, *AN ADVOCATE'S GUIDE TO HEALTH CARE FINANCING* 138-83 (1980).
 19. Medicare is the popular name for Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395pp (Supp. 1975). It was enacted as part of the Social Security Amendments of 1965 to provide health care benefits to eligible aged persons, and became effective on July 1, 1966. Medicaid is the popular name for Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396i (1974). Like Medicare, Medicaid was enacted as part of the Social Security Amendments of 1965 to provide health care benefits to eligible low-income and lower-middle-income persons.
 20. In 1964, poor people (family income under \$2,000) had the lowest rate of physician visits. Poor people (family income less than \$5,000 in 1976 and less than \$7,000 in 1981) had the highest rate of physician visits in those years. The hospital discharge rate among the poor increased, while rates for other income groups fell. These trends may be attributed in large part to a variety of federal programs, including Medicaid, which have improved the access of the poor to physicians and hospitals. ECONOMIC REPORT OF THE PRESIDENT, H.R. Doc. No. 19, 99th Cong., 1st Sess. 135-36 (1985) [hereinafter cited as ECONOMIC REPORT].
 21. Because of the complex restrictions, Medicaid excludes widows and other single persons under 65 and childless couples; most two-parent families (which constitute 70 percent of the rural poor and almost half the poor families in metropolitan areas); families with one parent working at a marginal, low-paying job; families with an unemployed parent in the 26 states that do not extend welfare payments to this group; unemployed parents receiving unemployment compensation in other states; medically needy families in the 22 states that do not voluntarily provide this additional coverage; single women pregnant with their first child in the 20 states that do not provide welfare aid or eligibility for the unborn child; and children of poor families not receiving Aid to Families with Dependent Children in the 33 states that do not take advantage of the optional Medicaid category "All needy children under 21." K. DAVIS & C. SCHOEN, *supra* note 15, at 53.

threshold in 1980 were ineligible for Medicaid.²² These people must rely on their own resources or funding provided by private charities.

For a variety of economic and non-economic reasons, many institutions will not provide government-sponsored care.²³ Discrimination against minorities, the handicapped, welfare recipients and other groups that are over-represented among the poor continues in medical care, as in other aspects of American life.²⁴ Poor nutrition, inferior housing, inadequate sanitation, and the physical and psychological stresses of unemployment and deprivation combine to aggravate the health problems of the poor.²⁵

THE BACKDROP FOR HILL-BURTON

The end of World War II brought thousands of soldiers back to the United States. These soldiers were accustomed to a high standard of health care,²⁶ and Congress wanted to assure that this level of care would continue to be provided in all parts of the country.²⁷ Concern was centered on the sheer lack of health care facilities, especially in rural areas.²⁸ It is against this backdrop that the Hill-Burton Act was introduced.

22. At the same time, about 5 million of those eligible had an annual family income at least twice the poverty level. It should be noted that the overwhelming emphasis of Medicaid is on institutional care. Of \$32.4 billion spent on Medicaid in fiscal 1983, hospitals received 27.2 percent for inpatient care. Payments to physicians represented only 6.7 percent of all Medicaid payments in fiscal 1983. See ECONOMIC REPORT, *supra* note 20, at 155.

Of the 19.3 million people covered by Medicaid in 1983, 13.2 million were below the poverty level, and 6 million were above it. See BUREAU OF THE CENSUS, U.S. DEPARTMENT OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES: 1986, at 101 (106th ed. 1985).

23. Because Medicaid is administered by each state, there are wide variations in eligibility requirements and in services covered. In some states, people may lose all of their eligibility if their income level rises slightly above the cutoff level; eligibility is not graduated according to income level. Because Medicaid costs have risen so quickly, states have been pressured to reduce their share of the rising costs. The methods usually used have been to reduce eligibility, reduce benefits, and reduce the amount paid to medical providers. The latter approach has, in some places, resulted in two different kinds of medical care: one for the Medicaid patient and the other for everyone else. Lower levels of reimbursement for Medicaid patients have limited the willingness of many providers to serve Medicaid patients. P. FELDSTEIN, HEALTH CARE ECONOMICS 540 (2nd ed. 1983).

24. Within the states there are variations in access to and use of services between white and nonwhite persons and between urban and rural dwellers. See *id.*; see generally Institute of Medicine, National Academy of Sciences, HEALTH CARE IN A CONTEXT OF CIVIL RIGHTS (1981).

25. K. DAVIS & C. SCHOEN, *supra* note 15, at 10.

26. During the course of the hearings, Sen. Johnston noted:

We now have millions of men and women in the armed forces who, for the first time in their lives, have had adequate hospital and medical care and it has been, I am proud to say, the finest in the world. We cannot expect them to forget these advantages when they return to private life, and, indeed, they will not do so. We have thousands of young doctors now in the armed forces, soon to be returned to civilian life, whose entire education and experience have been built around a modern hospital. They must have a place to work if we are to have adequate medical care in this country.

91 CONG. REC. 11,732 (1945).

27. See generally 1945 Hearings, *supra* note 3. Concern about the lack of adequate health care facilities around the country was the crux of the hearings.

28. See *id.*

Under Hill-Burton, the Surgeon General was required to prescribe the state plan requirements²⁹ and assurances necessary for the approval of hospital construction applications.³⁰ The Act requires that hospitals "furnish needed services for persons unable to pay therefore"³¹ and also gave the Surgeon General the option to require, as a precondition to approval, that the state give assurance that the hospitals would provide such services.³² All state plans had to be approved by the Surgeon General and the Secretary of Health and Human Services.³³ To be approved, the state application had to conform with the regulations promulgated under section 291c(e) of the Act.³⁴

In 1945, the Senate Committee on Education and Labor first discussed the Hill-Burton proposal.³⁵ Much of the discussion during the hearings was devoted to caring for the indigent.³⁶ These discussions are also illustrative of the premise, assumed in 1945, that hospitals would voluntarily provide services to all residents, including the indigent, out of their history of charitable service.³⁷ This premise proved to be unjustified, and the failure of the hospitals to provide health care to

29. 42 U.S.C. § 291c (1982). The Surgeon General prescribes the priority of projects, the standards of construction and equipment, the needs for beds, hospitals and other facilities, the criteria for determining need for modernization and state plan requirements. It should be noted that the Office of the Surgeon General was abolished by § 3 of Reorganization Plan No. 3 of 1966, F.R. 8855, 80 Stat. 1610 (1966), and all functions thereof were transferred to the Secretary of Health, Education and Welfare by § 1 of Reorganization Plan No. 3 of 1966, set out as a note under § 202 of Title 42.

30. 42 U.S.C. § 291c(e) (1982).

31. *Id.*

32. *Id.*

33. 42 U.S.C. § 291e(b) provides the criteria for approval of an application for construction or modernization, and requires that any plan be approved both by the Surgeon General and the Secretary of Health and Human Services. Since the function of the Surgeon General was transferred to the Secretary of Health and Human Services, this dual requirement has been extinguished.

34. *Id.* This section also requires:

(3) that the application is in conformity with the State plan approved under section 291d of this title and contains an assurance that in the operation of the project there will be compliance with the applicable requirements of the regulations prescribed under section 291c(e) of this title, and with State standards for operation and maintenance

35. See *supra* note 3 and accompanying text.

36. *Id.* at 10 (statement of Dr. Smelzer, President of the American Hospital Association); *id.* at 30 (statement of Sen. Chavez); *id.* at 34 (discussion between Dr. Smelzer and Sen. Ellender); *id.* at 177 (statement of Sen. Murray); *id.* at 190-91 (discussion between Sen. Ellender, Sen. Pepper, Sen. Taft, and Dr. Mott, an official of the Department of Agriculture). This last discussion is particularly illustrative. Sen. Pepper noted: "In determining the burden which the hospital would be expected to carry, they might not be able to get Federal aid unless they agreed to take a fixed number of indigent patients." *Id.* at 190. Sen. Taft responded that he believed "every hospital of a general nature would be lucky if they did not have 20 percent of indigent patients." *Id.*

37. This assumption can be seen in Dr. Smelzer's statement: "I think if this bill will provide the hospitals, will develop programs for the construction of such public and nonprofit hospitals, people who get into them will be taken care of at the local level." *Id.* at 30. Also indicative is Sen. Taft's comment: "You would say a hospital accepting aid of this kind should have obligation to take care of a certain number of indigent patients. Most of them do, but I mean if they are going to have Federal money, should there not be a definite obligation" *Id.* at 190.

the poor resulted in litigation to enforce the hospitals' community service and uncompensated care obligations in the early 1970s.³⁸

The 1972 Regulations

The free-health-care provisions of Hill-Burton were widely unenforced during the first twenty-five years.³⁹ Beginning in 1970, litigation revived interest in the long-forgotten assurances. In 1972, the Department of Health, Education and Welfare began to define the scope of the uncompensated care assurances more clearly in light of the pending litigation.⁴⁰

The regulations set forth a twenty-year limitation on the uncompensated care requirement.⁴¹ In addition, a presumptive compliance guideline was given, requiring hospitals to provide services at a level not less than the lesser of three percent of operating costs or ten percent of all federal assistance provided under the Act.⁴² The hospital could also comply by certifying that it would not exclude any person from admission on the grounds that he could not pay, the so-called "open door" provision.⁴³ Applicants had to submit compliance reports every year,⁴⁴ and if they had fallen behind in their provision of health care,

38. See, e.g., *Euresti v. Stenner*, 458 F.2d 1115 (10th Cir. 1972) (indigents had standing to maintain action to enforce Hill-Burton obligations); *Cook v. Ochsner Found. Hosp.*, 319 F. Supp. 603 (E.D. La. 1973) (poor persons in need of health services were beneficiaries of the legislation and had standing to sue grantees of Hill-Burton money and the state agency charged with enforcing the obligations); *Perry v. Greater Southeast Community Hosp. Found.*, Civ. No. 725-71 (D.C. June 28, 1972) (plaintiffs had standing to sue Health, Education and Welfare, the supervising agency for the District of Columbia and one Hill-Burton hospital); *OMICA v. James Archer Smith Hosp.*, 325 F. Supp. 268 (S.D. Fla. 1971) (plaintiffs had standing to sue; Health, Education and Welfare determined to be an indispensable party).

39. See Rose, *Federal Regulation of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls*, 70 Nw. U.L. Rev. 168, 169 (1975).

40. See *id.* at 174-76.

41. 42 C.F.R. § 53.111(a) (1986) provides:

The provisions of this section apply to every applicant which heretofore has given or hereafter will give an assurance that it will make available a reasonable volume of services to persons unable to pay therefor but shall not apply to an applicant (1) for more than 20 years after the completion of construction of any facility with respect to which funds have been paid under section 606 of the Act or (2) beyond the period during which any amount of a direct loan made under sections 610 or 623 of the Act, or any amount of a loan with respect to which a loan guarantee and interest subsidy has been provided under sections 623 and 624 of the Act remains unpaid.

42. 42 C.F.R. § 53.111(d)(1) (1986).

43. 42 C.F.R. § 53.111(d)(2) (1986) provides:

An applicant which, for a fiscal year . . . (2) certifies that it will not exclude any person from admission on the ground that such person is unable to pay for needed services and that it will make available to each person so admitted services provided by the facility without charge or at a charge below reasonable cost which does not exceed any such person's ability to pay therefor as determined in accordance with criteria established pursuant to paragraph (g), shall be deemed in presumptive compliance with its assurance.

44. 42 C.F.R. § 53.111(e)(1) (1986) provides:

Each applicant shall, not later than 120 days after the end of a fiscal year, unless a longer period is approved by the State agency for good cause shown, file with the State agency a copy of its annual statement for such year as required by section 6 of

had to give a justification and, if necessary, include an affirmative-action plan to create public awareness of the availability of such services.⁴⁵ Payments by third-party insurers and Medicare and Medicaid programs were excluded from the computation of uncompensated services.⁴⁶ Enforcement was left primarily to the state agency, which had to perform annual evaluations of compliance,⁴⁷ and provide for adequate methods of enforcement.⁴⁸

The Effect of Hill-Burton as Originally Passed

Viewed only as a construction bill, the Hill-Burton Act has been a smashing success.⁴⁹ By 1974, more than \$4 billion in Hill-Burton funds had been spent on construction and modernization of medical care facilities around the country.⁵⁰ From 1946 through 1973, the Hill-Burton program aided more than 3,900 communities in the construction and modernization of 6,445 public and voluntary non-profit facilities.⁵¹ In fact, Hill-Burton may have proved too successful in encouraging

the Act and § 53.128(q), which shall set forth its operating costs.

"State agency" is defined as "the agency of a State fully or conditionally designated by the Secretary as the State health planning and development agency under section 1521 of the Act."

42 C.F.R. § 124.502 (1986).

45. 42 C.F.R. § 53.111(e)(2)(ii) (1986) provides:

If the level of services provided was less than the level of uncompensated services established pursuant to paragraph (h) of this section, the applicant shall submit with such statement: A justification therefor, showing that the provision of such lower level of uncompensated services was reasonable under the circumstances; and a description of the steps it proposes to take to assure the availability and utilization of the level of uncompensated services to be established for the current fiscal year, which shall include an affirmative action plan, utilizing press releases or other appropriate means as the facility may desire to bring to the attention of the public the availability of such uncompensated services and the conditions of eligibility therefor.

46. 42 C.F.R. § 53.111(f)(2) (1986) provides:

There shall be excluded from the computation of uncompensated services: (i) Any amount which the applicant has received, or is entitled to receive, from a third party insurer or under a governmental program; and (ii) The reasonable cost of any services for which payment in whole or in part would be available under a governmental program (e.g., Medicare and Medicaid) in which the applicant, although eligible to do so, does not participate, but only to the extent of such otherwise available payment.

47. 42 C.F.R. § 53.111(j)(1) (1986) provides:

The State agency shall, (i) at least annually, perform evaluations of the amount of the various services provided in each facility with respect to which Federal assistance has been provided under the Act, to determine whether such assurance is being complied with; and (ii) establish procedures for the investigation of complaints that such assurance is not being complied with.

48. 42 C.F.R. § 53.111(j)(3) (1986) provides:

The State plan shall provide for adequate methods of enforcement of the assurance, including effective sanctions to be applied against any facility which fails to comply with such assurance. Such sanctions may include, but need not be limited to, license revocation, termination of State assistance, and court action.

49. S. REP. NO. 1285, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. CODE CONG. & ADMIN. NEWS 7842.

50. 1974 U.S. CODE CONG. & ADMIN. NEWS 7842, 7861 (appropriations increased from \$75 million in 1948 to \$197.2 million in 1974, peaking in 1967 at \$270 million).

51. *Id.* at 7862.

hospital construction—as early as 1974, some experts believed that there was a surplus of hospital beds in the United States.⁵²

Although Hill-Burton has succeeded in increasing hospital facilities, it has failed to significantly increase health services to the poor. While readily accepting construction funds, the compliance records of the hospitals receiving Hill-Burton funds have been less than satisfactory. Even after twenty-seven years, the implementation of the free-service requirements was in its infancy at the state level.⁵³ No state agencies had an active program for monitoring compliance, but rather intended to rely on complaints to do so.⁵⁴ The assumption that hospitals would provide free health care based on their history of charitable care proved to be unjustified.⁵⁵

Judicial Interpretation of Hill-Burton

Litigation continued after 1972 in order to enforce the newly promulgated regulations. In *Corum v. Beth Israel Medical Center*,⁵⁶ a federal district court invalidated a regulation allowing hospitals to credit toward their Hill-Burton obligations care that was rendered to patients whose Hill-Burton eligibility was not determined until after the patients were billed. Of major concern to the court was the problem that after-the-fact determination discouraged many poor, potential beneficiaries from seeking medical assistance, due to the uncertainty of their status.⁵⁷ The court concluded that the discouraging influence of the provision was antithetical to the goals of the Act.⁵⁸

A crucial decision regarding plaintiffs' rights was *Newsom v. Vanderbilt University*.⁵⁹ The district court recognized a constitutionally protected property right of each indigent patient "to needed uncom-

52. The Act by this point had enabled construction of a sufficient number of hospitals to satisfy the needs of the community. The emphasis of most state Hill-Burton plans was shifted to the maintenance of these facilities through loans and grants for modernization. *Id.* at 7966.

53. *Id.* at 7900.

54. This was characterized by the Committee on Labor and Public Welfare as a "sorry performance by the Department and the State Hill-Burton agencies in implementing a provision which has been in law for over 20 years." *Id.*

55. See *American Hosp. Ass'n v. Schweiker*, 721 F.2d 170, 177 (10th Cir. 1983), *cert. denied*, 466 U.S. 958 (1984). The court, in discussing the 1945 Hearings, found that there was a contemporary assumption that hospitals would voluntarily provide charitable services at little or no cost to the poor. It is also noted that the hospitals' compliance with the assurances later inserted into the bill may have been taken for granted once the federal government enabled them to construct facilities.

56. 373 F. Supp. 550 (S.D.N.Y. 1974).

57. The court noted:

If a hospital is not obliged to make a determination of indigency prior to the rendition of services, many truly indigent persons may incur liabilities to it in the hope of qualifying for free or below cost services, which they will later be hard pressed to pay if the hospital declines to treat them as beneficiaries of its Hill-Burton assurance on the ground that by the time of billing its requirement has been satisfied.

Id. at 557.

58. *Id.*

59. 453 F. Supp. 401 (M.D. Tenn. 1978), *aff'd in part, modified in part, and rev'd in part*, 653 F.2d 1100 (6th Cir. 1981).

pensated services under the Hill-Burton Act.”⁶⁰ The court further held that the hospital had denied the patient procedural due process.⁶¹ The court held that due process required individual notice by the hospital of the availability of free Hill-Burton care, plus written eligibility criteria for the allocation of the care.⁶² Any individual denied Hill-Burton care had to receive “timely and adequate written notice detailing the reasons for the proposed denial of benefits, review by a decision-maker who [had] not participated in making the initial finding of ineligibility, and a written statement of the reasons for the decision and the evidence relied on.”⁶³ The court of appeals later reversed the ruling that each individual indigent plaintiff had a right to services.⁶⁴ By the time it was reversed, however, the district court decision had already helped to prompt the Secretary of Health and Human Services to promulgate the 1979 regulations.

The courts in these cases accepted the argument advanced on behalf of indigents that the focus of the program should be on individual patients.⁶⁵ Indeed, the *Corum* court, in stating that it would be antithetical to the goals of Hill-Burton to discourage potential patients from seeking free health care, impliedly assumed that the uncompensated health care provisions of the Act were of central importance.⁶⁶

The rulings in *Corum* and *Newsom* were judicial reactions to the reluctance of the hospitals to fulfill even the minimal requirements as set forth in the original Act. Were it not for the almost complete lack of compliance, these cases may never have reached the courts.⁶⁷ The

60. The court noted that “the Act itself defines persons entitled to uncompensated care as being those ‘unable to pay therefor,’ a statutory standard of eligibility which the plaintiff class, by definition, meets.” 453 F.Supp. at 423.

61. *Id.* at 422-23 (citing *Board of Regents v. Roth*, 408 U.S. 564, 577 (1972)).

62. 453 F. Supp. at 424.

63. *Id.*

64. The court of appeals held that “although the class may have a right to have the hospital give benefits to some of the class members and thus has standing under the statute, no individual has a legitimate claim to free services such that the procedures provided in the present case infringe a due process right.” 653 F.2d at 1121.

65. This proposition can be seen in several early cases. In *Euresti v. Stenner*, 458 F.2d 1115 (10th Cir. 1972), the court held that “the legislative history and the expressed purposes of Congress indicate that the Act was passed to ensure that the indigent would be supplied sufficient hospital services when needed.” *Id.* at 1118. The district court in *Newsom v. Vanderbilt Univ.*, 453 F. Supp. 401 (M.D. Tenn. 1978) noted that “[T]he inclusion of the free care provisions . . . makes it plain that one of the needs Congress felt to be unmet in 1946, and still inadequately met in 1974, was the need for medical care for the indigent.” *Id.* at 422, n. 15. The court in *Cook v. Ochsner Found. Hosp.*, 319 F. Supp. 603 (E.D. La. 1973), found that it was not even necessary to delve into the legislative history of the Act, and that

[t]he Act, by its own terms, makes it plain that persons unable to pay for medical services are one of the chief sets of beneficiaries of this legislation. It is a matter of the clearest logic that the only real beneficiaries of a hospital program are the people who need or may need medical treatment. This includes people of all classes, whether rich or poor.

Id. at 606.

66. See 373 F. Supp. at 555, 557.

67. As the court in *American Hosp. Ass’n v. Schweiker*, 721 F.2d 170 (7th Cir. 1983), *cert. denied*, 466 U.S. 958 (1984) noted, “although over \$4.4 billion in grants and \$2 billion in

failure of hospitals to provide care for the indigent resulted in litigation to enforce the federally assisted hospitals' community service and uncompensated health care obligations under Hill-Burton.⁶⁸ It appears that the hospitals have no one to blame but their administrators. The courts were not seeking to transform Hill-Burton; they were merely trying to force the hospitals to furnish that which they had promised in return for Hill-Burton funds.

The 1979 Regulations

In response to pressure by those seeking better enforcement of compliance guidelines, Health and Human Services⁶⁹ proposed new regulations in 1978. The regulations represent an extensive revision of the uncompensated care and community-service assurances of Hill-Burton. They reflect a developing realization that Congress intended not only to aid construction, but also to aid people in the community. The 1979 regulations retain a quantitative measure of compliance. A hospital may fulfill its uncompensated-care assurance by furnishing care to qualified patients amounting to three percent of its annual operating costs⁷⁰ or by providing care amounting to ten percent of the annual Hill-Burton financial assistance received by the hospital.⁷¹ The open-door treatment option was eliminated.⁷² The basis for establishing the

loans and loan guarantees were authorized between 1947 and 1974 . . . the hospitals receiving aid displayed a marked reluctance to give even the most token charitable care." 721 F.2d at 173.

68. The court stated: "After—and apparently in response to—a series of lawsuits brought by several private citizens and public interest groups against federally assisted hospitals to enforce compliance with the Hill-Burton obligations . . . the Secretary began in 1972 to issue regulations which defined standards for compliance with the assurances." *Id.*

69. Health and Human Services is the successor to Health, Education and Welfare. 20 U.S.C. § 3508 (1982).

70. 42 C.F.R. § 124.503(a)(1)(i) (1986) provides:

A facility is in compliance with its assurance to provide a reasonable volume of services to persons unable to pay if it provides for the fiscal year uncompensated services at a level not less than the lesser of: (i) Three percent of its operating costs for the most recent fiscal year for which an audited financial statement is available; . . . adjusted by a percentage equal to the percentage change in the national Consumer Price Index for medical care between the year in which the facility received assistance or 1979, whichever is later, and the most recent year for which a published Index is available.

71. 42 C.F.R. § 124.503(a)(1)(ii) (1986) adds:

A facility is in compliance with its assurance to provide a reasonable volume of services to persons unable to pay if it provides for the fiscal year uncompensated services at a level not less than the lesser of: . . . (ii) Ten percent of all Federal assistance provided to or on behalf of the facility, adjusted by a percentage equal to the percentage change in the national Consumer Price Index for medical care between the year in which the facility received assistance or 1979, whichever is later, and the most recent year for which a published Index is available.

72. See 44 Fed. Reg. 29,372, 29,385 (1979). Health and Human Services explained:

The Department continues to believe that elimination of the open door option is necessary for the reasons stated in the preamble to the proposed rules and by many consumers. A clear dollar standard against which facility performance can be measured will simplify monitoring and administration, gain public confidence that a "reasonable volume" of services has in fact been made available, and will result in facilities shouldering relatively equal minimum obligations to serve the medically indigent.

appropriate level of free care is adjusted upward annually in accordance with the Consumer Price Index for medical care.⁷³ Shortfalls in any year must be added to future years' obligation, beyond the twenty-year obligation, and adjusted for inflation.⁷⁴

THE FAILURE OF FREE HEALTH CARE UNDER HILL-BURTON: A CASE STUDY

Despite the protests of hospitals and commentators, hospitals do not substantially comply with the free-health-care provisions of the Act. Even since the promulgation of the 1979 regulations, there has been substantial noncompliance. A 1981 study of twenty-one Hill-Burton facilities in North Dakota is illustrative of this point.⁷⁵ Only one facility fully complied with the requirements.⁷⁶ Fourteen sites had incurred a Hill-Burton deficit in 1980.⁷⁷ Of these fourteen, nine failed to file a report with the Secretary of Health and Human Services as required by the regulations.⁷⁸ Of the five that did submit a report, two were inaccurate.⁷⁹ All of this adds up to a great loss of health care for the poor. The correction of Hill-Burton crediting and compliance level errors at only eleven of the facilities meant that these facilities would have to provide \$63,478 more in Hill-Burton care in 1982.⁸⁰ The margin

73. See *supra* notes 70-71.

74. 42 C.F.R. § 124.503(b) (1986) provides:

If in any fiscal year a facility assisted under Title VI of the Act fails to meet its annual compliance level, it shall provide uncompensated services in an amount sufficient to make up that deficit (as adjusted under paragraph (d)). The facility may make up a deficit at any time during its period of obligation or in the year or years (if necessary) immediately following, except where the facility failed to provide uncompensated services at the required level although financially able to do so, or where the facility did not comply with the requirements of this subpart.

Section (d)(2) additionally provides:

The amount of any deficit the facility makes up, and the amount of any excess compliance applied to reduce a facility's annual compliance level, must be adjusted by a percentage equal to the percentage change in the National Consumer Price Index for medical care between the fiscal year in which the facility had a deficit or provided the excess, and the fiscal year in which the facility makes up the deficit or applies the excess to reduce its annual compliance level or satisfy its remaining obligations.

75. See O'Neil, *Site Visits at 21 Hill-Burton Facilities Reveal Extensive Non-Compliance*, 16 CLEARINGHOUSE REV. 404 (1982). In this study, site visits were made by Legal Assistance of North Dakota to 21 Hill-Burton facilities between February and June of 1981.

76. See *id.* at 406-07.

77. Of 21 facilities visited, 15 either had no Hill-Burton journal or used an incomplete journal. Nine of the 21 had eligibility determination forms that regularly lacked the information required by the Hill-Burton regulations, or that failed to indicate changes in eligibility and amounts of Hill-Burton coverage in cases in which an eligibility determination was initially made and later reversed. See *id.* at 410.

78. 42 C.F.R. § 124.510(a)(1)(ii)(A) (1986) provides: "If the facility determines that in the preceding fiscal year it did not provide uncompensated services at the annual compliance level, it shall submit a report in the fiscal year in which the deficit is determined."

79. Inaccuracies were found in the free-care figures supplied by the hospitals. See O'Neil, *supra* note 75, at 410.

80. The amount of the Hill-Burton deficit incurred by the hospitals, \$63,478, represented 43.9 percent of the total amount of Hill-Burton care provided by these facilities in fiscal year 1980. *Id.* at 411.

of error at ten of the facilities ranged from \$439 to \$17,900.⁸¹ Assuming the report reflects nationwide levels of noncompliance, indigent patients are denied millions of dollars in free health care yearly.⁸² Even the burdens imposed by the 1979 regulations have failed to insure compliance. The reluctance to comply with the Act means the people most desperately in need of health care have one less source from which to obtain it.

Many, if not most, Hill-Burton facilities do not provide the requisite amount of free health care to the poor. The question remains whether Hill-Burton should be used to provide free health care to the poor. The argument against the provision of free health care centers on a reading of the Act as providing only for the construction of health care facilities.⁸³ At least one critic of the regulations argues that the original language of the Act is distinguishable from the highly regulatory nature that the free-health-care assurances have assumed.⁸⁴ The Act was not meant to solve the problem of lack of health care for the indigent, nor was it meant to be a "mini-Medicaid" program.⁸⁵ It was intended to provide facilities so that all people, including the indigent, could enjoy better and more frequent health care.⁸⁶ It was the reluctance of hospitals to provide a reasonable volume of free health care that necessitated the regulations.

The Constitutional Challenges

Many of the challenges to the regulations center on the holding of *Pennhurst v. Halderman*.⁸⁷ *Pennhurst* addressed the question of whether a new federal statute, the "bill of rights" provision of the Develop-

81. *Id.* at 413. The study set up a chart of 10 of the facilities, their compliance levels, the amount of free care provided in 1980 and the site visit error correction. Site visit error correction amounts involve corrections in both the amounts facilities were obligated to offer (compliance level) and the amounts they claimed to have provided as Hill-Burton care (their Hill-Burton credits). Correction amounts involve corrections made in more than one fiscal year under the current regulations for some facilities.

82. Assuming that all of the approximately 7,000 facilities aided by Hill-Burton failed to meet their 1980 obligations by the same amount as the 11 hospitals studied, the loss would be well over \$40 million. This is a conservative estimate, since North Dakota is sparsely populated. North Dakota ranked 46th in population in 1980, with a population of 653,000. By comparison, California ranked first in population at 23,668,000. See BUREAU OF THE CENSUS, U.S. DEPARTMENT OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES: 1986 at 10-11 (106th ed. 1985).

83. See, e.g., Note, *supra* note 8, at 1475. The author argues that Hill-Burton was designed only to deal with the construction of hospitals and related facilities and not to serve as a small-scale national health insurance program. She separates the provision of physical facilities for furnishing adequate health services from the provision of the services themselves.

84. *Id.* at 1478. The author concedes that Congress intended grantee hospitals to devote some of its resources to providing free care, but argues that this does not justify the complex nature of the regulations.

85. See Blumstein, *supra* note 9, at 1244; Note, *supra* note 8, at 1475.

86. See *supra* note 3 and accompanying text.

87. 451 U.S. 1 (1981).

mentally Disabled Assistance and Bill of Rights Act,⁸⁸ conferred an enforceable substantive right upon mentally retarded persons.⁸⁹ The Supreme Court held that the provision created no substantive rights to "appropriate treatment" in the "least restrictive" environment.⁹⁰

The Court noted that legislation enacted pursuant to Congress' spending power is much in the nature of a contract—in return for federal funds, states agree to comply with federally imposed conditions.⁹¹ For legislative power to be legitimate, states must voluntarily accept the terms of the contract.⁹² There cannot be a knowing acceptance if the state is unaware of the conditions or is unable to ascertain what is expected of it.⁹³ If Congress intends to impose conditions upon the granting of funds, it must do so unambiguously.⁹⁴

As a result of the decision, in the absence of clear notice, "the Court will not impose onerous financial obligations on federal grantees after-the-fact."⁹⁵ Under this rationale, if the hospitals could prove that the advocates for indigent plaintiffs were reading too much into the legislative history or that the regulations impaired the contract rights of the defendant hospitals, they could have the regulations struck.

A plaintiff used the contract theory in *American Hospital Association v. Schweiker*.⁹⁶ In this case, the plaintiff sued on behalf of hospitals receiving funds under Hill-Burton to have regulations that impose community-service and uncompensated-care obligations declared invalid, arguing that they violated statutory, contractual and constitutional rights.⁹⁷

88. 42 U.S.C. § 6010(1)-(2) (1982). The Act established a federal-state grant program whereby the federal government provides financial assistance to participating states to aid them in creating programs to care for and treat the developmentally disabled. The "bill of rights" provision states that mentally retarded persons have a right to appropriate treatment, services, and habilitation in the setting that is least restrictive of personal liberty.

89. 451 U.S. at 5.

90. The Court examined the legislative history and found that it "buttresses . . . [the] conclusion that Congress intended to encourage, rather than mandate, the provision of better services to the developmentally disabled." *Id.* at 20.

The purpose of Hill-Burton in funding hospital construction was to insure that all people of the state would have adequate health and hospital service. Legislators did not intend Hill-Burton to "encourage" the provision of health care; rather Congress intended it to mandate the provision of adequate health care to all people who used the federally funded facility. This includes those who are unable to pay.

91. *Id.* at 17.

92. *Id.*

93. *Id.*

94. *Id.* By insisting that Congress speak clearly, the Court enables states to realize the consequences of their participation in such programs as Hill-Burton.

95. *Id.* at 25.

96. 721 F.2d 170 (7th Cir. 1983), *cert. denied*, 466 U.S. 958 (1984).

97. The American Hospital Association argued that the 1979 regulations exceed the Secretary's statutory authority, that they violate contractual agreements between the federal government and the hospitals by altering and expanding their obligations under those agreements, and that they violate the due process clause by impairing the hospitals' contractual rights. 721 F.2d at 175, 182.

What is particularly interesting, and a bit ironic, is that none of the challenges made to Hill-Burton attacked funding for modernization. The modernization of hospitals was not the concern of the Hill-Burton Act; its concern was the construction of facilities. Despite this, a complaint has yet to be raised that modernization funds were outside the original scope of the Act and, as such, should have been eliminated.

The court rejected the contract theory, noting that Title XVI mandates the Secretary of Health and Human Services to prescribe the manner in which all recipients of aid shall be required to comply with the assurances given at the time the assistance was received.⁹⁸ The court determined that the Secretary was acting within the scope of his statutory mandate in promulgating the regulations.⁹⁹

In dealing with the impairment of contractual obligations claim, the court found that a grant-in-aid program, such as Hill-Burton, was within Congress' spending power.¹⁰⁰ The court also dismissed the argument that the hospitals were unsure of their obligations under the Act.¹⁰¹ They found that the conditions were unambiguously stated¹⁰² and that the applicants had signed a very open-ended contract, one which conferred a great deal of discretion upon the Secretary to define the measure of their obligations under it.¹⁰³ In *Wyoming Hospital Association v. Harris*,¹⁰⁴ the court of appeals agreed with the rationale of *Schweiker* and upheld the requirements.¹⁰⁵

THE PROPOSED REVISIONS

The Department of Health and Human Services proposed revisions to the regulations.¹⁰⁶ These revisions are an attempt to lessen the

98. *Id.* at 174. In 1975, Hill-Burton was amended by Title XVI of the Public Health Service Act, codified at 42 U.S.C. § 300q *et seq.*; it provides for assurances similar to those in Title VI, but adds teeth to the requirements. Title XVI mandates, rather than permits, the Secretary to prescribe by regulation the manner in which all recipients of aid under either Title VI or Title XVI shall be required to comply with the assurances given at the time such assistance was received and the means by which the hospital will be required to demonstrate compliance with such assurances. See 42 U.S.C. § 300s(3) (1982). The Secretary is also given extensive investigative and enforcement powers by Title XVI. See 42 U.S.C. § 300s-6 (1982).

99. *Id.* at 176.

100. *Id.* at 182-83 ("The government acts by inducing a state or private party to cooperate with the federal policy by conditioning receipt of federal aid upon compliance by the recipient with federal statutory and administrative directives").

101. *Id.* at 183. The contracts contained general statements of the requirements and of the statutory obligation imposed by 42 U.S.C. § 291c(e).

102. *Id.*

103. *Id.* at 184.

104. 727 F.2d 936 (10th Cir. 1984).

105. In this case, the plaintiffs sought declaratory and injunctive relief from enforcement of the Hill-Burton regulations. The court held that the Secretary's decision to limit the uncompensated care credit was rationally based and within his discretion. *Id.* at 940.

Other recent cases have followed the same rationale. In *Intermountain Health Care Hosp. Inc. v. Board of Comm'rs*, 108 Idaho 136, 697 P.2d 1150 (1985), *rev'd on other grounds*, 108 Idaho 757, 702 P.2d 795 (1985), the court stated simply: "[W]e note at the outset that, as a recipient of federal funds under the Hill-Burton Act . . . the hospital has obligated itself to provide a certain level and amount of care to the medically indigent." 697 P.2d at 1158. In *John Muir Memorial Hosp. Inc. v. Davis*, 559 F. Supp. 1042 (N.D. Cal. 1983), *aff'd*, 726 F.2d 1443 (9th Cir. 1983), the court held that "once a hospital accepts a Hill-Burton grant, it is legally bound to provide free health care and may be penalized for its failure to do so." 559 F. Supp. at 1044. Finally, in *Metropolitan Medical Center and Extended Care Facility v. Harris*, 693 F.2d 775 (8th Cir. 1982), the court examined the legislative history of Hill-Burton and concluded that Congress intended that Hill-Burton hospitals devote some of their own resources to the poor. *Id.* at 785.

106. 51 Fed. Reg. 31,000 (1986) (to be codified at 42 C.F.R. subpart F) (proposed Aug. 29, 1986).

administrative burden of compliance for facilities, while increasing incentive for compliance by facilities in order to protect the interests of the intended beneficiaries of the uncompensated-services assurance.¹⁰⁷ If these proposals are implemented, not only would the administrative burden on the facilities be lessened, but the already low level of compliance by these facilities would sink even lower.

Under the proposed rules, a facility in substantial compliance with the regulations would receive credit for its compliance.¹⁰⁸ Substantial compliance, however, is not a defined term under the regulations. Additionally, the facility would be given credit if it had substantially complied with the rules "despite aberrations on individual accounts."¹⁰⁹ Litigation about what constitutes substantial compliance would be sure to follow any challenge to a facility's level of compliance. The implementation of a substantial compliance standard would merely shift the financial burden on Health and Human Services from the cost of auditing to the cost of litigation.

Another disturbing proposal would implement the concept of justifiable deficits.¹¹⁰ This concept would include the situation in which a facility could show that there existed a lack of eligible applicants for uncompensated services during the fiscal year.¹¹¹ This proposal would face the same inherent problem that plagued the open-door compliance level:¹¹² there would be no way to monitor it effectively. If a facility claimed there was a lack of eligible applicants, Health and Human Services would be hard pressed to refute that claim, especially since the proposed rules would greatly relax reporting requirements.¹¹³

Another proposed change would allow facilities to hire an independent auditor to determine the amount of creditable uncompensated services provided.¹¹⁴ The danger of an independent audit is that there would be tremendous incentive to bribery or payoff to alter the records kept by the facility. This danger could be largely circumvented by requiring Health and Human Services to perform the audit.¹¹⁵

Finally, the proposed rules would eliminate the requirement under the current regulations that facilities send reports to the health systems agency in their area.¹¹⁶ The rationale advanced for this change is that the requirement is unnecessary, since facilities are not required to

107. Health and Human Services noted that the existing regulations rely on strict adherence to procedural requirements, and believes that a relaxing of the regulations would make it easier on hospitals and stimulate compliance. *Id.* at 31,001.

108. See proposed § 124.511(b)(1), 51 Fed. Reg. 31,010-11.

109. *Id.* at 31,004.

110. *Id.* at 31,002.

111. See proposed § 124.503(b)(1), 51 Fed. Reg. 31,007.

112. See *supra* note 72.

113. See *id.* at 31,001.

114. See proposed § 124.511(b)(1)(ii), 51 Fed. Reg. 31,011. The only effort by Health and Human Services to monitor the audit procedures is to "make guidance materials available." *Id.* at 31,004.

115. See Appendix, proposed addition to § 124.511(a)(1).

116. This requirement is currently codified in subsections of 42 C.F.R. § 124.510 (1986).

implement recommendations that they may receive from the health systems agency.¹¹⁷ The elimination of this requirement would simply mean that there would be one less source available to detect noncompliance.

Although many of the proposed rules are beneficial, any changes made to the regulations should demand strict adherence to procedural requirements. Allowing for substantial compliance, independent audits, justifiable deficits and the elimination of reporting requirements hardly provides incentive for compliance. If the interests of the intended beneficiaries of uncompensated care are truly the concern of Health and Human Services, then more stringent requirements should be implemented.

A PROPOSED SOLUTION TO THE ENFORCEMENT PROBLEM

Despite the plaintive cries of hospitals receiving Hill-Burton funds, courts have found an affirmative duty to provide free health care. This has not, however, had much of an effect on hospitals around the country. Instead of providing required health care, they defer satisfaction of their uncompensated health care obligation, theoretically into eternity.¹¹⁸ Although this benefits the hospitals, it leaves the indigent without the health care to which they are entitled.

Two proposals would increase compliance. The first of the changes would be to establish a small auditing team within Health and Human Services that would conduct nationwide site checks.¹¹⁹ The North Dakota study shows that site checks can detect noncompliance.¹²⁰ Although auditors could only study a limited number of facilities each year, the threat of being audited would make hospital administrators more conscious of Hill-Burton obligations.¹²¹

The second proposal incorporates the first into the regulatory framework of the Act. The proposal consists of two amendments to 42 C.F.R. § 124.511.¹²² The first amendment involves investigation of compliance by the Secretary of Health and Human Services.¹²³ This addition to the

117. 51 Fed. Reg. 31,004-05.

118. See *supra* note 74 and accompanying text. A facility can make up its deficit at any time during its period of obligation or in the years following, if necessary, unless the facility failed to provide uncompensated services at the required level when they were financially capable of doing so. As the Legal Assistance of North Dakota study indicates, hospitals frequently overstate the amount of services they provided. Unless an audit is performed, it appears as though the hospital is in compliance.

119. This proposal is in accordance with 42 C.F.R. § 124.511 (1986), which gives enforcement authority to the federal government. This proposal also retains the option of state reporting and enforcement requirements under § 124.512.

120. See *supra* notes 75-82 and accompanying text.

121. The emphasis should center on facilities whose 20-year obligation is about to expire. The number of obligated hospitals drops yearly. If audits were centered on those facilities about to be discharged, detection of noncompliance would extend their obligations, rather than grant the discharge, thus maximizing the amount of services available to the indigent.

122. See Appendix, proposed amendments to § 124.511.

123. 42 C.F.R. § 124.511(a)(1) (1986) currently provides:

(a) *Investigations.* (1) The Secretary periodically investigates the compliance of facilities with the requirements of this subpart, and investigates complaints.

section mandates an audit of Hill-Burton facilities to determine compliance. By mandating an audit, the proposal would require the Secretary to seek out noncompliance rather than wait for complaints. The second amendment involves the enforcement of the regulations by the Secretary.¹²⁴ It provides for a financial penalty if a facility fails to keep records as required by the regulations.¹²⁵ The North Dakota study indicates that poor record keeping is commonplace amongst recipient hospitals.¹²⁶ This amendment provides incentive to recipient hospitals to keep accurate, up-to-date records on compliance.¹²⁷ In addition, it helps to alleviate cost concerns that critics might have.¹²⁸

CONCLUSION

Although Hill-Burton has been successful at building medical facilities across the country, hospitals still fail to provide free health care to those most desperately in need of it. Hospitals have shown they will not comply with targets if left to their own devices. Hill-Burton should not be used as a Medicaid program. However, since hospitals have accepted funding from the federal government, they should at least comply with the conditions attached to the funding. Recent Health and Human Services proposals will most likely discourage compliance, and will make it easier for hospitals to avoid their Hill-Burton obligation. Health and Human Services should promulgate more stringent regulations such as those suggested here to compel Hill-Burton hospitals to provide the free health care that they promised when they received funding.

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124. 42 C.F.R. § 124.511(b)(1) (1986) currently provides:

(b) *Enforcement.* (1) If the Secretary finds, based on his investigation under paragraph (a) of this section, that a facility did not comply with the requirements of this subpart, he may take any action authorized by law to secure compliance, including but not limited to voluntary agreement or a request to the Attorney General to bring an action against the facility for specific performance.

125. The proposed addition requires that any facility whose records are not in compliance be required to pay the reasonable cost of the audit to Health and Human Services. This should not be viewed as a penalty, but rather as compensation for the cost of straightening out the records that the facility is required to keep under § 124.510. *See* Appendix, proposed addition to § 124.511(b)(1).

Since facilities are required to keep these records, any challenge made to this proposal on the grounds of impairment of contract or due process would likely be unsuccessful. As the court in *American Hosp. Ass'n v. Schweiker*, 721 F.2d 170 (7th Cir. 1983), *cert. denied*, 466 U.S. 958 (1984) noted, any challenge to regulations promulgated by the Secretary of Health and Human Services must show that the regulations are "arbitrary, capricious, an abuse of discretion or not in accordance with the law." 721 F.2d 170 at 175. The standard is one of deference; the decision of the agency will be affirmed if it has any rational basis. *Id.* at 175-76.

126. *See supra* notes 78-79 and accompanying text.

127. Under this proposal, if a facility is audited, and it is discovered that its records are complete and properly kept and that the facility is in compliance with the Act, the cost of the audit is absorbed by the federal government. *See* Appendix, proposed addition to § 124.511(b)(1).

128. The proposal would need initial funding from Health and Human Services, but the cost to the government would be reimbursed by any facility not in compliance with the record keeping requirements of the regulations. If the North Dakota study is any indicator, cost to the government would be negligible.

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APPENDIX**PROPOSED AMENDMENT TO § 124.511**

Add to (a)(1):

The periodic investigation performed by the Secretary shall consist of an audit of the records that each facility is required to keep under this subpart.

Add to (b)(1):

If the Secretary finds, based on an audit of a facility that 1) the facility did not keep records as required under this subpart, or 2) that the records are inaccurate, incomplete or otherwise not in compliance with this subpart, the facility shall be required to reimburse Health and Human Services for the reasonable costs of the audit performed.